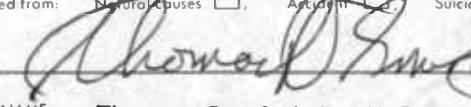
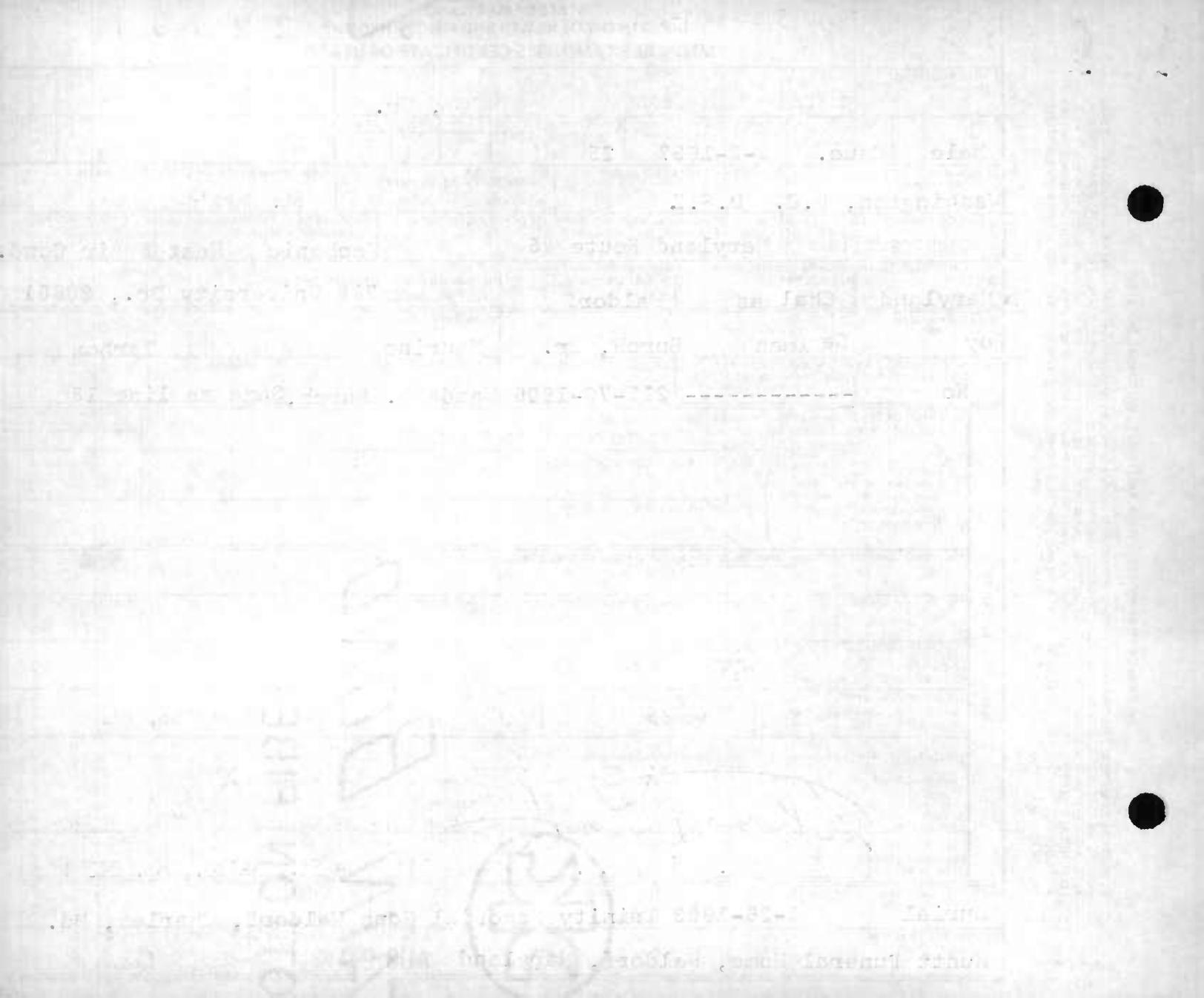


5
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 14 DAYS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> OF EST. DEATH MATED <input type="checkbox"/> 8/22/83 19									2b. HOUR MONTH DAY YEAR					
I DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR MONTH DAY YEAR			
Jeffrey			Scott			Burch, Sr.						8/22/83 19		8:00 P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
Male		Cauc.		9-3-1957			25 yrs.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Washington, D.C.		U.S.A.								St. Mary's County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Mechanicsville		Maryland Route #5										Mechanic		Heat & Air Cond.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Charles		Waldorf						168 University Dr., 20601							
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST					
Roy		Sellman		Burch, Sr.			Maurine					Tarbox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		16c. INFORMANT			16d. ADDRESS										
		215-70-1906		Wanda B. Burch, Same as line 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound to Chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:15 P.M. 8/22 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot			21d. LOCATION STREET		CITY OR TOWN Mechanicsville, Md.		COUNTY Charles		STATE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Woods			21f. LOCATION STREET												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE  Thomas D. Smith, M.D.														TITLE (SPECIFY) Deputy Chief		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201										DATE SIGNED 8/24/83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-1983			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial Gdns			23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.			COUNTY Charles		STATE				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland		ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 29 1983			25b. REGISTRAR'S SIGNATURE 									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove or tear off the top portion of the certificate and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22582			
1. DECEASED NAME [TYPE OR PRINT]										REG. NO.			
EVERETT ALPHONSUS CHESELDINE										August 9, 1983			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE [IN YEARS LAST BIRTHDAY]		7b. HOUR					
Male		White		MONTH DAY YEAR April 3, 1910		73 YRS.		2:10 P.M.					
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Colton Point, Md. USA						St. Mary's County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown,		St. Mary's Hospital											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS			
13b. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		St. Mary's		Colton Point		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Gen. Del. 20626					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Nelson		Elizabeth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO				Everett A. Cheseldine Jr.		same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>										Hours.			
4/100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Boyd</i>		22c. DATE SIGNED 8-7-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
William D. Boyd, II M.D.		Leonardtown, Maryland 20650											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Aug. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE					
Burial						Bushwood, St. Mary's, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 22 1983		25b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>							
W. Clarke Mattingley		Leonardtown, Maryland											

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DEPARTMENT

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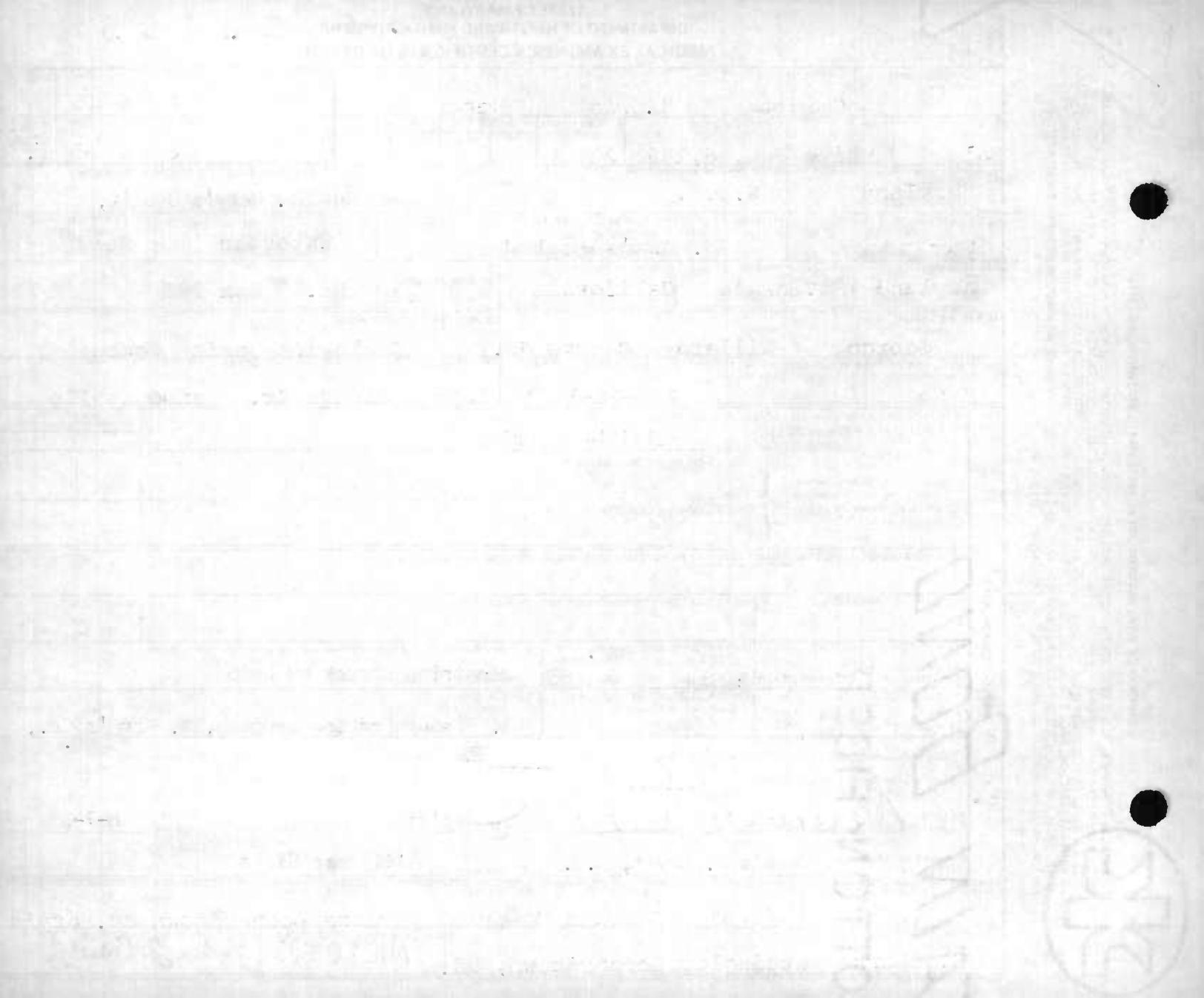
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22583											
												REG. NO.											
1- STATE REGISTRAR																							
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR						
Charles			Lewis			Clarke			<input checked="" type="checkbox"/>		8	6	1983	2d HOUR 2:30 a.m.									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR					
Male		White		Jan. 26, 1961		22 yrs.		MONTHS		DAYS		HOURS		MIN		8		6		1983			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.									<input checked="" type="checkbox"/>			<input type="checkbox"/>			St. Mary's County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Leonardtown			St. Mary's Hospital									Waterman			Self								
13. STATE			14. COUNTY		15. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS		20619												
Maryland			St. Mary's		California		<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO		Rt. 2		Box 205										
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME											
George			Willard			Clarke Jr.						Catherine Marie Combs											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
No			220-78-1091			George Clarke Jr.			same as 13e														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple Injuries																							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?											
												<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			pedestrian struck by auto														
1:20 P.M.			est. 8 6 1983																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
			Road						Rt. 5 south of Leonardtown, St. Mary's Co., Md.														
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.												TITLE (SPECIFY) Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									DATE SIGNED 8-7-83											
Dennis F. Smyth, M.D.			111 Penn Street																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY			STATE					
Burial			8/8/83			Charles Memorial Gardens			Leonardtown			St. Mary's											
24. FUNERAL DIRECTOR NAME			ADDRESS									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
W. Clarke Mattingley			Leonardtown, Md.									AUG 10 1983			John G. Smith								
20M 4/B																							
DHMH - 17																							
(VR A15 ME (5))																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

83 22584

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			MABEL	MARGUERITE	DAILEY	August 17, 1983				11:09 ^P			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Female		white		Mar. 30, 1905		78							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's				MD.			
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital											
13a. STATE Maryland						13b. COUNTY St. Mary's		13c. CITY OR TOWN Avenue		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 6A	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Winfield			Maddox			Sadie			Curtain				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			577-84-7129			Kay Firestein			same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u>													
3109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multifocal decarb. but no cereb.</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic brain. syndrome</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1983</u> to <u>Aug 17, 1983</u> , that (I) (we) last saw the deceased alive on <u>Aug 12, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Youngsik Moon, M.D.</u> DEGREE													
22c. PHYSICIAN'S NAME (TYPE OR PRINT)						22d. ADDRESS Hollywood, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		STATE			
Burial		8/20/83		Charles Memorial Gardens		Leonardtown		St. Mary's Md.					
24. FUNERAL DIRECTOR NAME <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>													
25a. DATE REC'D. BY REGISTRAR <u>AUG 22 1983</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

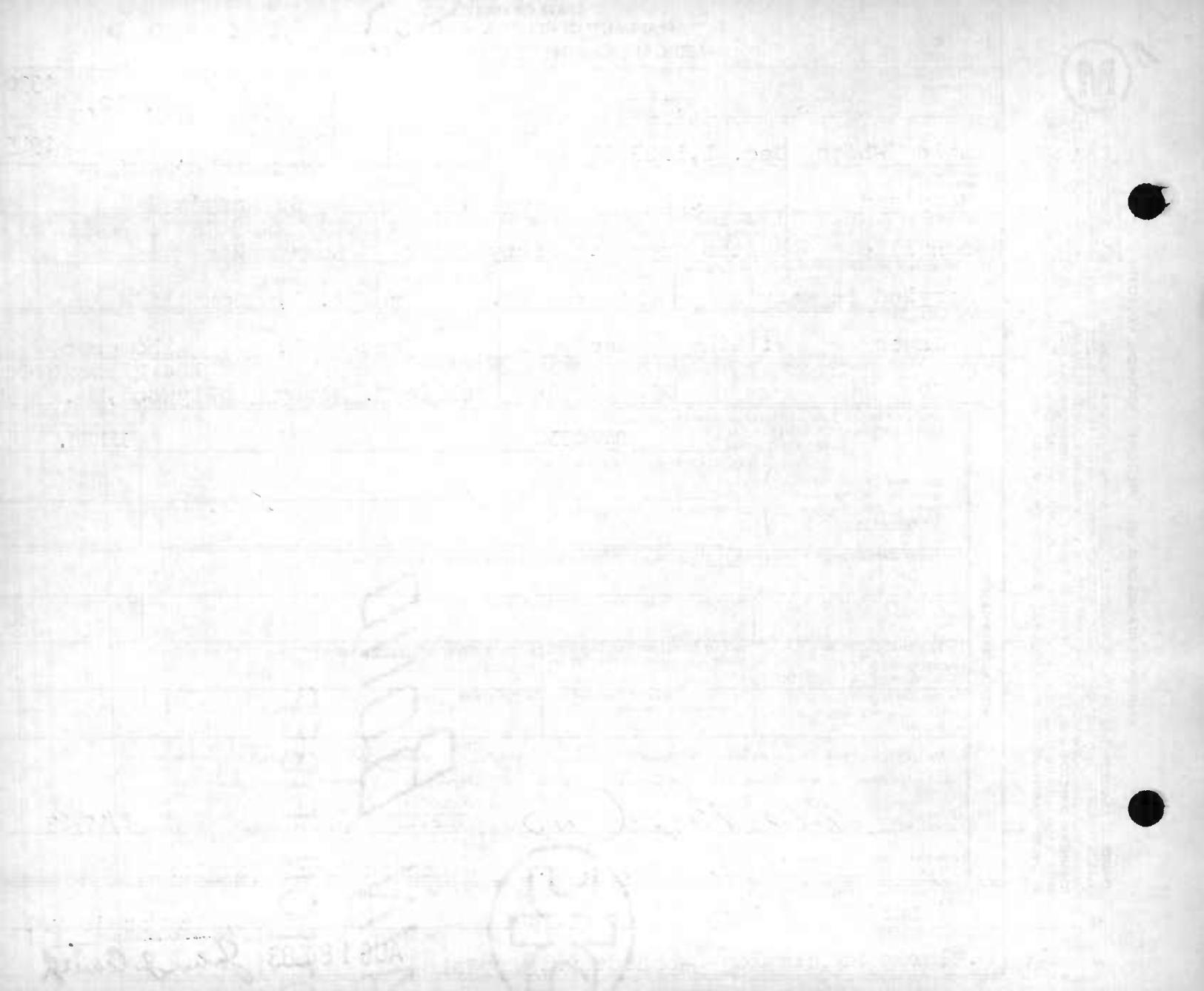
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 3 2 2 8 5					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		20. DATE OF DEATH		MONTH	DAY	YEAR	21b. HOUR	
ELLA ANN EMBREY									August 17, 1983					10:30AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.					
Female		caucasion		Sept. 5, 1885		97		MONTHS DAYS		MONTHS HOURS MIN.					
YRS.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Virginia		U.S.A.				St. Mary's County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Leonardtown		St. Mary's Hospital		House Wife		Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Calvert		Lusby		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 100L Olivet Rd. 20657							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
James E.				Whitlock		Kate				Shackelford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. ADDRESS									
No		224-72-0394		Mr. James W. Embrey Lusby, Md. 20657		Box 100 L. Olivet Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360										Cerebrovascular Accident e left- Hemiplegia -					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										16 days.					
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Congestive heart failure, Chronic Obstetrics, lung disease.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTO/ST.		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-30-1983 to 8/16/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Salim Yousaf		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/17/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Z Yousaf, M.D.		22e. ADDRESS		Prince Frederick, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-20-83		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Cemetery		23d. LOCATION CITY OR TOWN Alexandria		COUNTY		STATE Virginia					
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home		NAME alex,		1500 W Braddock Rd Va22302		25a. DATE REC'D. BY REGISTRAR AUG 24 1983		25b. REGISTRAR'S SIGNATURE John J. Cawley							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22586		
1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)						LAST		2a. DATE KNOWN FOR DEATH OR ESTIMATE		MONTH DAY YEAR		
		AGNES ESTHER FERGUSON								AUG. 12, 1983		1390 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2b. DATE PRONOUNCED DEAD		MONTH DAY YEAR
Female		White		Dec. 1, 1925		57 yrs.						Aug. 12, 1983		1915 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA		<input type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> DIVORCED		St Mary's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Beachville		Smiths Creek at Kitty Point						Home maker		2016 63				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		Rt. 1, Box 194W				
Maryland		St Mary's		Lexington Pk.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
James		William		Burroughs		Martha R.				Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS				
NO		220 16 8049						Debbie F. Alvey		104 Pleasant Ct Hollywood, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9109 IMMEDIATE CAUSE (a) DROWNING												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR P.M. 19		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER										DATE SIGNED 8/17/83		
EXAMINER'S NAME (TYPE OR PRINT)		William D. Boyd, M. D. ADDRESS Leonardtown, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE		
Burial		8/16/1983		St Johns		Hollywood		Hollywood		St Mary's Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
W. Clarke Mattingley		Leonardtown, Maryland		AUG 18 1983		John G. Conroy								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DMMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22587

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
EDNA			MORRIS			HALL			August 28, 1983							1:00 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May			DAY 21		YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87			IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County														
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife						12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Ridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 461			20680								
14. FATHER'S NAME FIRST Henry		MIDDLE Morris		15. MOTHER'S MAIDEN NAME Sarah			17. INFORMANT ADDRESS P.O. Box 461 Eloise H. Peterson, Ridge, Maryland 20680						LAST McIntosh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. (IF YES, GIVE WAR OR DATES) No		16c. SOCIAL SECURITY NO. 223-50-9540			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z, 1aa, 1ab, 1ac, 1ad, 1ae, 1af, 1ag, 1ah, 1ai, 1aj, 1ak, 1al, 1am, 1an, 1ao, 1ap, 1aq, 1ar, 1as, 1au, 1av, 1aw, 1ax, 1ay, 1az, 1aa1, 1ab1, 1ac1, 1ad1, 1ae1, 1af1, 1ag1, 1ah1, 1ai1, 1aj1, 1ak1, 1al1, 1am1, 1an1, 1ao1, 1ap1, 1aq1, 1ar1, 1as1, 1au1, 1av1, 1aw1, 1ax1, 1ay1, 1az1, 1aa2, 1ab2, 1ac2, 1ad2, 1ae2, 1af2, 1ag2, 1ah2, 1ai2, 1aj2, 1ak2, 1al2, 1am2, 1an2, 1ao2, 1ap2, 1aq2, 1ar2, 1as2, 1au2, 1av2, 1aw2, 1ax2, 1ay2, 1az2, 1aa3, 1ab3, 1ac3, 1ad3, 1ae3, 1af3, 1ag3, 1ah3, 1ai3, 1aj3, 1ak3, 1al3, 1am3, 1an3, 1ao3, 1ap3, 1aq3, 1ar3, 1as3, 1au3, 1av3, 1aw3, 1ax3, 1ay3, 1az3, 1aa4, 1ab4, 1ac4, 1ad4, 1ae4, 1af4, 1ag4, 1ah4, 1ai4, 1aj4, 1ak4, 1al4, 1am4, 1an4, 1ao4, 1ap4, 1aq4, 1ar4, 1as4, 1au4, 1av4, 1aw4, 1ax4, 1ay4, 1az4, 1aa5, 1ab5, 1ac5, 1ad5, 1ae5, 1af5, 1ag5, 1ah5, 1ai5, 1aj5, 1ak5, 1al5, 1am5, 1an5, 1ao5, 1ap5, 1aq5, 1ar5, 1as5, 1au5, 1av5, 1aw5, 1ax5, 1ay5, 1az5, 1aa6, 1ab6, 1ac6, 1ad6, 1ae6, 1af6, 1ag6, 1ah6, 1ai6, 1aj6, 1ak6, 1al6, 1am6, 1an6, 1ao6, 1ap6, 1aq6, 1ar6, 1as6, 1au6, 1av6, 1aw6, 1ax6, 1ay6, 1az6, 1aa7, 1ab7, 1ac7, 1ad7, 1ae7, 1af7, 1ag7, 1ah7, 1ai7, 1aj7, 1ak7, 1al7, 1am7, 1an7, 1ao7, 1ap7, 1aq7, 1ar7, 1as7, 1au7, 1av7, 1aw7, 1ax7, 1ay7, 1az7, 1aa8, 1ab8, 1ac8, 1ad8, 1ae8, 1af8, 1ag8, 1ah8, 1ai8, 1aj8, 1ak8, 1al8, 1am8, 1an8, 1ao8, 1ap8, 1aq8, 1ar8, 1as8, 1au8, 1av8, 1aw8, 1ax8, 1ay8, 1az8, 1aa9, 1ab9, 1ac9, 1ad9, 1ae9, 1af9, 1ag9, 1ah9, 1ai9, 1aj9, 1ak9, 1al9, 1am9, 1an9, 1ao9, 1ap9, 1aq9, 1ar9, 1as9, 1au9, 1av9, 1aw9, 1ax9, 1ay9, 1az9, 1aa10, 1ab10, 1ac10, 1ad10, 1ae10, 1af10, 1ag10, 1ah10, 1ai10, 1aj10, 1ak10, 1al10, 1am10, 1an10, 1ao10, 1ap10, 1aq10, 1ar10, 1as10, 1au10, 1av10, 1aw10, 1ax10, 1ay10, 1az10, 1aa11, 1ab11, 1ac11, 1ad11, 1ae11, 1af11, 1ag11, 1ah11, 1ai11, 1aj11, 1ak11, 1al11, 1am11, 1an11, 1ao11, 1ap11, 1aq11, 1ar11, 1as11, 1au11, 1av11, 1aw11, 1ax11, 1ay11, 1az11, 1aa12, 1ab12, 1ac12, 1ad12, 1ae12, 1af12, 1ag12, 1ah12, 1ai12, 1aj12, 1ak12, 1al12, 1am12, 1an12, 1ao12, 1ap12, 1aq12, 1ar12, 1as12, 1au12, 1av12, 1aw12, 1ax12, 1ay12, 1az12, 1aa13, 1ab13, 1ac13, 1ad13, 1ae13, 1af13, 1ag13, 1ah13, 1ai13, 1aj13, 1ak13, 1al13, 1am13, 1an13, 1ao13, 1ap13, 1aq13, 1ar13, 1as13, 1au13, 1av13, 1aw13, 1ax13, 1ay13, 1az13, 1aa14, 1ab14, 1ac14, 1ad14, 1ae14, 1af14, 1ag14, 1ah14, 1ai14, 1aj14, 1ak14, 1al14, 1am14, 1an14, 1ao14, 1ap14, 1aq14, 1ar14, 1as14, 1au14, 1av14, 1aw14, 1ax14, 1ay14, 1az14, 1aa15, 1ab15, 1ac15, 1ad15, 1ae15, 1af15, 1ag15, 1ah15, 1ai15, 1aj15, 1ak15, 1al15, 1am15, 1an15, 1ao15, 1ap15, 1aq15, 1ar15, 1as15, 1au15, 1av15, 1aw15, 1ax15, 1ay15, 1az15, 1aa16, 1ab16, 1ac16, 1ad16, 1ae16, 1af16, 1ag16, 1ah16, 1ai16, 1aj16, 1ak16, 1al16, 1am16, 1an16, 1ao16, 1ap16, 1aq16, 1ar16, 1as16, 1au16, 1av16, 1aw16, 1ax16, 1ay16, 1az16, 1aa17, 1ab17, 1ac17, 1ad17, 1ae17, 1af17, 1ag17, 1ah17, 1ai17, 1aj17, 1ak17, 1al17, 1am17, 1an17, 1ao17, 1ap17, 1aq17, 1ar17, 1as17, 1au17, 1av17, 1aw17, 1ax17, 1ay17, 1az17, 1aa18, 1ab18, 1ac18, 1ad18, 1ae18, 1af18, 1ag18, 1ah18, 1ai18, 1aj18, 1ak18, 1al18, 1am18, 1an18, 1ao18, 1ap18, 1aq18, 1ar18, 1as18, 1au18, 1av18, 1aw18, 1ax18, 1ay18, 1az18, 1aa19, 1ab19, 1ac19, 1ad19, 1ae19, 1af19, 1ag19, 1ah19, 1ai19, 1aj19, 1ak19, 1al19, 1am19, 1an19, 1ao19, 1ap19, 1aq19, 1ar19, 1as19, 1au19, 1av19, 1aw19, 1ax19, 1ay19, 1az19, 1aa20, 1ab20, 1ac20, 1ad20, 1ae20, 1af20, 1ag20, 1ah20, 1ai20, 1aj20, 1ak20, 1al20, 1am20, 1an20, 1ao20, 1ap20, 1aq20, 1ar20, 1as20, 1au20, 1av20, 1aw20, 1ax20, 1ay20, 1az20, 1aa21, 1ab21, 1ac21, 1ad21, 1ae21, 1af21, 1ag21, 1ah21, 1ai21, 1aj21, 1ak21, 1al21, 1am21, 1an21, 1ao21, 1ap21, 1aq21, 1ar21, 1as21, 1au21, 1av21, 1aw21, 1ax21, 1ay21, 1az21, 1aa22, 1ab22, 1ac22, 1ad22, 1ae22, 1af22, 1ag22, 1ah22, 1ai22, 1aj22, 1ak22, 1al22, 1am22, 1an22, 1ao22, 1ap22, 1aq22, 1ar22, 1as22, 1au22, 1av22, 1aw22, 1ax22, 1ay22, 1az22, 1aa23, 1ab23, 1ac23, 1ad23, 1ae23, 1af23, 1ag23, 1ah23, 1ai23, 1aj23, 1ak23, 1al23, 1am23, 1an23, 1ao23, 1ap23, 1aq23, 1ar23, 1as23, 1au23, 1av23, 1aw23, 1ax23, 1ay23, 1az23, 1aa24, 1ab24, 1ac24, 1ad24, 1ae24, 1af24, 1ag24, 1ah24, 1ai24, 1aj24, 1ak24, 1al24, 1am24, 1an24, 1ao24, 1ap24, 1aq24, 1ar24, 1as24, 1au24, 1av24, 1aw24, 1ax24, 1ay24, 1az24, 1aa25, 1ab25, 1ac25, 1ad25, 1ae25, 1af25, 1ag25, 1ah25, 1ai25, 1aj25, 1ak25, 1al25, 1am25, 1an25, 1ao25, 1ap25, 1aq25, 1ar25, 1as25, 1au25, 1av25, 1aw25, 1ax25, 1ay25, 1az25, 1aa26, 1ab26, 1ac26, 1ad26, 1ae26, 1af26, 1ag26, 1ah26, 1ai26, 1aj26, 1ak26, 1al26, 1am26, 1an26, 1ao26, 1ap26, 1aq26, 1ar26, 1as26, 1au26, 1av26, 1aw26, 1ax26, 1ay26, 1az26, 1aa27, 1ab27, 1ac27, 1ad27, 1ae27, 1af27, 1ag27, 1ah27, 1ai27, 1aj27, 1ak27, 1al27, 1am27, 1an27, 1ao27, 1ap27, 1aq27, 1ar27, 1as27, 1au27, 1av27, 1aw27, 1ax27, 1ay27, 1az27, 1aa28, 1ab28, 1ac28, 1ad28, 1ae28, 1af28, 1ag28, 1ah28, 1ai28, 1aj28, 1ak28, 1al28, 1am28, 1an28, 1ao28, 1ap28, 1aq28, 1ar28, 1as28, 1au28, 1av28, 1aw28, 1ax28, 1ay28, 1az28, 1aa29, 1ab29, 1ac29, 1ad29, 1ae29, 1af29, 1ag29, 1ah29, 1ai29, 1aj29, 1ak29, 1al29, 1am29, 1an29, 1ao29, 1ap29, 1aq29, 1ar29, 1as29, 1au29, 1av29, 1aw29, 1ax29, 1ay29, 1az29, 1aa30, 1ab30, 1ac30, 1ad30, 1ae30, 1af30, 1ag30, 1ah30, 1ai30, 1aj30, 1ak30, 1al30, 1am30, 1an30, 1ao30, 1ap30, 1aq30, 1ar30, 1as30, 1au30, 1av30, 1aw30, 1ax30, 1ay30, 1az30, 1aa31, 1ab31, 1ac31, 1ad31, 1ae31, 1af31, 1ag31, 1ah31, 1ai31, 1aj31, 1ak31, 1al31, 1am31, 1an31, 1ao31, 1ap31, 1aq31, 1ar31, 1as31, 1au31, 1av31, 1aw31, 1ax31, 1ay31, 1az31, 1aa32, 1ab32, 1ac32, 1ad32, 1ae32, 1af32, 1ag32, 1ah32, 1ai32, 1aj32, 1ak32, 1al32, 1am32, 1an32, 1ao32, 1ap32, 1aq32, 1ar32, 1as32, 1au32, 1av32, 1aw32, 1ax32, 1ay32, 1az32, 1aa33, 1ab33, 1ac33, 1ad33, 1ae33, 1af33, 1ag33, 1ah33, 1ai33, 1aj33, 1ak33, 1al33, 1am33, 1an33, 1ao33, 1ap33, 1aq33, 1ar33, 1as33, 1au33, 1av33, 1aw33, 1ax33, 1ay33, 1az33, 1aa34, 1ab34, 1ac34, 1ad34, 1ae34, 1af34, 1ag34, 1ah34, 1ai34, 1aj34, 1ak34, 1al34, 1am34, 1an34, 1ao34, 1ap34, 1aq34, 1ar34, 1as34, 1au34, 1av34, 1aw34, 1ax34, 1ay34, 1az34, 1aa35, 1ab35, 1ac35, 1ad35, 1ae35, 1af35, 1ag35, 1ah35, 1ai35, 1aj35, 1ak35, 1al35, 1am35, 1an35, 1ao35, 1ap35, 1aq35, 1ar35, 1as35, 1au35, 1av35, 1aw35, 1ax35, 1ay35, 1az35, 1aa36, 1ab36, 1ac36, 1ad36, 1ae36, 1af36, 1ag36, 1ah36, 1ai36, 1aj36, 1ak36, 1al36, 1am36, 1an36, 1ao36, 1ap36, 1aq36, 1ar36, 1as36, 1au36, 1av36, 1aw36, 1ax36, 1ay36, 1az36, 1aa37, 1ab37, 1ac37, 1ad37, 1ae37, 1af37, 1ag37, 1ah37, 1ai37, 1aj37, 1ak37, 1al37, 1am37, 1an37, 1ao37, 1ap37, 1aq37, 1ar37, 1as37, 1au37, 1av37, 1aw37, 1ax37, 1ay37, 1az37, 1aa38, 1ab38, 1ac38, 1ad38, 1ae38, 1af38, 1ag38, 1ah38, 1ai38, 1aj38, 1ak38, 1al38, 1am38, 1an38, 1ao38, 1ap38, 1aq38, 1ar38, 1as38, 1au38, 1av38, 1aw38, 1ax38, 1ay38, 1az38, 1aa39, 1ab39, 1ac39, 1ad39, 1ae39, 1af39, 1ag39, 1ah39, 1ai39, 1aj39, 1ak39, 1al39, 1am39, 1an39, 1ao39, 1ap39, 1aq39, 1ar39, 1as39, 1au39, 1av39, 1aw39, 1ax39, 1ay39, 1az39, 1aa40, 1ab40, 1ac40, 1ad40, 1ae40, 1af40, 1ag40, 1ah40, 1ai40, 1aj40, 1ak40, 1al40, 1am40, 1an40, 1ao40, 1ap40, 1aq40, 1ar40, 1as40, 1au40, 1av40, 1aw40, 1ax40, 1ay40, 1az40, 1aa41, 1ab41, 1ac41, 1ad41, 1ae41, 1af41, 1ag41, 1ah41, 1ai41, 1aj41, 1ak41, 1al41, 1am41, 1an41, 1ao41, 1ap41, 1aq41, 1ar41, 1as41, 1au41, 1av41, 1aw41, 1ax41, 1ay41, 1az41, 1aa42, 1ab42, 1ac42, 1ad42, 1ae42, 1af42, 1ag42, 1ah42, 1ai42, 1aj42, 1ak42, 1al42, 1am42, 1an42, 1ao42, 1ap42, 1aq42, 1ar42, 1as42, 1au42, 1av42, 1aw42, 1ax42, 1ay42, 1az42, 1aa43, 1ab43, 1ac43, 1ad43, 1ae43, 1af43, 1ag43, 1ah43, 1ai43, 1aj43, 1ak43, 1al43, 1am43, 1an43, 1ao43, 1ap43, 1aq43, 1ar43, 1as43, 1au43, 1av43, 1aw43, 1ax43, 1ay43, 1az43, 1aa44, 1ab44, 1ac44, 1ad44, 1ae44, 1af44, 1ag44, 1ah44, 1ai44, 1aj44, 1ak44, 1al44, 1am44, 1an44, 1ao44, 1ap44, 1aq44, 1ar44, 1as44, 1au44, 1av44, 1aw44, 1ax44, 1ay44, 1az44, 1aa45, 1ab45, 1ac45, 1ad45, 1ae45, 1af45, 1ag45, 1ah45, 1ai45, 1aj45, 1ak45, 1al45, 1am45, 1an45, 1ao45, 1ap45, 1aq45, 1ar45, 1as45, 1au45, 1av45, 1aw45, 1ax45, 1ay45, 1az45, 1aa46, 1ab46, 1ac46, 1ad46, 1ae46, 1af46, 1ag46, 1ah46, 1ai46, 1aj46, 1ak46, 1al46, 1am46, 1an46, 1ao46, 1ap46, 1aq46, 1ar46, 1as46, 1au46, 1av46, 1aw46, 1ax46, 1ay46, 1az46, 1aa47, 1ab47, 1ac47, 1ad47, 1ae47, 1af47, 1ag47, 1ah47, 1ai47, 1aj47, 1ak47, 1al47, 1am47, 1an47, 1ao47, 1ap47, 1aq47, 1ar47, 1as47, 1au47, 1av47, 1aw47, 1ax47, 1ay47, 1az47, 1aa48, 1ab48, 1ac48, 1ad48, 1ae48, 1af48, 1ag48, 1ah48, 1ai48, 1aj48, 1ak48, 1al48, 1am48, 1an48, 1ao48, 1ap48, 1aq48, 1ar48, 1as48, 1au48, 1av48, 1aw48, 1ax48, 1ay48, 1az48, 1aa49, 1ab49, 1ac49, 1ad49, 1ae49, 1af49, 1ag49, 1ah49, 1ai49, 1aj49, 1ak49, 1al49, 1am49, 1an49, 1ao49, 1ap49, 1aq49, 1ar49, 1as49, 1au49, 1av49, 1aw49, 1ax49, 1ay49, 1az49, 1aa50, 1ab50, 1ac50, 1ad50, 1ae50, 1af50, 1ag50, 1ah50, 1ai50, 1aj50, 1ak50, 1al50, 1am50, 1an50, 1ao50, 1ap50, 1aq50, 1ar50, 1as50, 1au50, 1av50, 1aw50, 1ax50, 1ay50, 1az50, 1aa51, 1ab51, 1ac51, 1ad51, 1ae51, 1af51, 1ag51, 1ah51, 1ai51, 1aj51, 1ak51, 1al51, 1am51, 1an51, 1ao51, 1ap51, 1aq51, 1ar51, 1as51, 1au51, 1av51, 1aw51, 1ax51, 1ay51, 1az51, 1aa52, 1ab52, 1ac52, 1ad52, 1ae52, 1af52, 1ag52, 1ah52, 1ai52, 1aj52, 1ak52, 1al52, 1am52, 1an52, 1ao52, 1ap52, 1aq52, 1ar52, 1as52, 1au52, 1av52, 1aw52, 1ax52, 1ay52, 1az52, 1aa53, 1ab53, 1ac53, 1ad53, 1ae53, 1af53, 1ag53, 1ah53, 1ai53, 1aj53, 1ak53, 1al53, 1am53, 1an53, 1ao53, 1ap53, 1aq53, 1ar53, 1as53, 1au53, 1av53, 1aw53, 1ax53, 1ay53, 1az53, 1aa54, 1ab54, 1ac54, 1ad54, 1ae54, 1af54, 1ag54, 1ah54, 1ai54, 1aj54, 1ak54, 1al54, 1am54, 1an54, 1ao54, 1ap54, 1aq54, 1ar54, 1as54, 1au54, 1av54, 1aw54, 1ax54, 1ay54, 1az54, 1aa55, 1ab55, 1ac55, 1ad55, 1ae55, 1af55, 1ag55, 1ah55, 1ai55, 1aj55, 1ak55, 1al55, 1am55, 1an55, 1ao55, 1ap55, 1aq55, 1ar55, 1as55, 1au55, 1av55, 1aw55, 1ax55, 1ay55, 1az55, 1aa56, 1ab56, 1ac56, 1ad56, 1ae56, 1af56, 1ag56, 1ah56, 1ai56, 1aj56, 1ak56, 1al56, 1am56, 1an56, 1ao56, 1ap56, 1aq56, 1ar56, 1as56, 1au56, 1av56, 1aw56, 1ax56, 1ay56, 1az56, 1aa57, 1ab57, 1ac57, 1ad57, 1ae57, 1af57, 1ag57, 1ah57, 1ai57, 1aj57, 1ak57, 1al57, 1am57, 1an57, 1ao57, 1ap57, 1aq57, 1ar57, 1as57, 1au57, 1av57, 1aw57, 1ax57, 1ay57, 1az57, 1aa58, 1ab58, 1ac58, 1ad58, 1ae58, 1af58, 1ag58, 1ah58, 1ai58, 1aj58, 1ak58, 1al58, 1am58, 1an58, 1ao58, 1ap58, 1aq58, 1ar58, 1as58, 1au58, 1av58, 1aw58, 1ax58, 1ay58, 1az58, 1aa59, 1ab59, 1ac59, 1ad59, 1ae59, 1af59, 1ag59, 1ah59, 1ai59, 1aj59, 1ak59, 1al59, 1am59, 1an59, 1ao59, 1ap59, 1aq59, 1ar59, 1as59, 1au59, 1av59, 1aw59, 1ax59, 1ay59, 1az59, 1aa60, 1ab60, 1ac60, 1ad60, 1ae60, 1af60, 1ag60, 1ah60, 1ai60, 1aj60, 1ak60, 1al60, 1am60, 1an60, 1ao60, 1ap60, 1aq60, 1ar60, 1as60, 1au60, 1av60, 1aw60, 1ax60, 1ay60, 1az60, 1aa61, 1ab61, 1ac61, 1ad61, 1ae61, 1af61, 1ag61, 1ah61, 1ai61, 1aj61, 1ak61, 1al61, 1am61, 1an61, 1ao61, 1ap61, 1aq61, 1ar61, 1as61, 1au61, 1av61, 1aw61, 1ax61, 1ay61, 1az61, 1aa62, 1ab62, 1ac62, 1ad62, 1ae62, 1af62, 1ag62, 1ah62, 1ai62, 1aj62, 1ak62, 1al62, 1am62, 1an62, 1ao62, 1ap62, 1aq62, 1ar62, 1as62, 1au62, 1av62, 1aw62, 1ax62, 1ay62, 1az62, 1aa63, 1ab63, 1ac63, 1ad63, 1ae63, 1af63, 1ag63, 1ah63, 1ai63, 1aj63, 1ak63, 1al63, 1am63, 1an63, 1ao63, 1ap63, 1aq63, 1ar63, 1as63, 1au63, 1av63, 1aw63, 1ax63, 1ay63, 1az63, 1aa64, 1ab64, 1ac64, 1ad64, 1ae64, 1af64, 1ag64, 1ah64, 1ai64, 1aj64, 1ak64, 1al64, 1am64, 1an64, 1ao64, 1ap64, 1aq64, 1ar64, 1as64, 1au64, 1av64, 1aw64, 1ax64, 1ay64, 1az64, 1aa65, 1ab65, 1ac65, 1ad65, 1ae65, 1af65, 1ag65, 1ah65, 1ai65, 1aj65, 1ak65, 1al65, 1am65, 1an65, 1ao65, 1ap65, 1aq65, 1ar65, 1as65, 1au65, 1av65, 1aw65, 1ax65, 1ay65, 1az65, 1aa66, 1ab66, 1ac66, 1ad66, 1ae66, 1af66, 1ag66, 1ah66, 1ai66, 1aj66, 1ak66, 1al66, 1am66, 1an66, 1ao66, 1ap66, 1aq66, 1ar66, 1as66, 1au66, 1av66, 1aw66, 1ax66, 1ay66, 1az66, 1aa67, 1ab67, 1ac67, 1ad67, 1ae67, 1af67, 1ag67, 1ah67, 1ai67, 1aj67, 1ak67, 1al67, 1am67, 1an67, 1ao67, 1ap67, 1aq67, 1ar67, 1as67, 1au67, 1av67, 1aw67, 1ax67, 1ay67, 1az67, 1aa68, 1ab68, 1ac68, 1ad68, 1ae68, 1af68, 1ag68, 1ah68, 1ai68, 1aj68, 1ak68, 1al68, 1am68, 1an68, 1ao68, 1ap68, 1aq68, 1ar68, 1as68, 1au68, 1av68, 1aw68, 1ax68, 1ay68, 1az68, 1aa69, 1ab69, 1ac69, 1ad69, 1ae69, 1af69, 1ag69, 1ah69, 1ai69, 1aj69, 1ak69, 1al69, 1am69, 1an69, 1ao69, 1ap69, 1aq69, 1ar69, 1as69, 1au69, 1av69, 1aw69, 1ax69, 1ay69, 1az69, 1aa70, 1ab70, 1ac70, 1ad70, 1ae70, 1af70, 1ag70, 1ah70, 1ai70, 1aj70, 1ak70, 1al70, 1am70, 1an70, 1ao70, 1ap70, 1aq70, 1ar70, 1as70, 1au70, 1av70, 1aw70, 1ax70, 1ay70, 1az70, 1aa71, 1ab71, 1ac71, 1ad71, 1ae71, 1af71, 1ag71, 1ah71, 1ai71, 1aj71, 1ak71, 1al71, 1am71, 1an71, 1ao71, 1ap71, 1aq71, 1ar71, 1as71, 1au71, 1av71, 1aw71, 1ax71, 1ay71, 1az71, 1aa72, 1ab72, 1ac72, 1ad72, 1ae72, 1af72, 1ag72, 1ah72, 1ai72, 1aj72, 1ak72, 1al72, 1am72, 1an72, 1ao72, 1ap72, 1aq72, 1ar72, 1as72, 1au72, 1av72, 1aw72, 1ax72, 1ay72, 1az72, 1aa73, 1ab73, 1ac73, 1ad73, 1ae73, 1af73, 1ag73, 1ah73, 1ai73, 1aj73, 1ak73, 1al73, 1am73, 1an73, 1ao73, 1ap73, 1aq73, 1ar73, 1as73, 1au73, 1av73, 1aw73, 1ax73, 1ay73, 1az73, 1aa74, 1ab74, 1ac74, 1ad74, 1ae74, 1af74, 1ag74, 1ah74, 1ai74, 1aj74, 1ak74, 1al74, 1am74, 1an74, 1ao74, 1ap74, 1aq74, 1ar74, 1as74, 1au74, 1av74, 1aw74, 1ax74, 1ay74, 1az74, 1aa75, 1ab75, 1ac75, 1ad75, 1ae75, 1af75, 1ag75, 1ah75, 1ai75, 1aj75, 1ak75, 1al75, 1am75, 1an75, 1ao75, 1ap75, 1aq75, 1ar75, 1as75, 1au75, 1av75, 1aw75, 1ax75, 1ay75, 1az75, 1aa76, 1ab76, 1ac76, 1ad76, 1ae76, 1af76, 1ag76, 1ah76, 1ai76, 1aj76, 1ak76, 1al76, 1am76, 1an76, 1ao76, 1ap76, 1aq76, 1ar76, 1as76, 1au76, 1av76, 1aw76, 1ax76, 1ay76, 1az7														

19.00: 1

1900-1901 43

Les équations d'ordre 3 et 4 sont démontrées de la même manière.

02005: *Indonesia, two branches*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 2 5 8 8		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
JAMES ARDY JOHNSON						August 7, 1983			5:05 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		Feb. 7 1899			84			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					St. Mary's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR TRADE					
Lexington Park		Amber House Nursing Home		Carpenter			Building Trades					
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Indian Head			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 413 D 20640		
14. FATHER'S NAME FIRST William		MIDDLE Johnson		15. MOTHER'S MAIDEN NAME FIRST Ellen Lee Mason						LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-1600367		17. INFORMANT ADDRESS James A. Johnson Edgewater, Fla 32032								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 3109 IMMEDIATE CAUSE (a) <i>Pneumonia</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Brain Syndrome</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to <i>Hypertension, Cerebral Heart Failure</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/26/1983 to 8/7/1983, that (I) (we) lost saw the deceased alive on 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the deceased after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/9/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D.		22e. ADDRESS Medical Arts Bldg., Leonardtown, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-83		23c. NAME OF CEMETERY OR CREMATORY Old Durham Ch. Cem.			23d. LOCATION CITY OR TOWN Charles		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE John J. Conigli				
BP												

issued 5 copies
2/14/84/84

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22589
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	X	MONTH	DAY	YEAR	7b. HOUR	
CLYDE GARFIELD MAHONEY						8-19-83	19				M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Male	White	12 1 1932	50	YRS.		-19-83	19				10:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Connecticut		U.S.A.				St. Mary's County MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Dameron		Rt. 235 Dameron, Maryland			Musician							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME				
Maryland		St. Mary's	Scotland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rodo Beach 20687		FIRST Wilfred				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-40-1351			17. INFORMANT		MIDDLE LAST Mahoney					
					Sandy G. Mahoney, Scotland, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF 8/50 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 1:30 AM 8-19-83 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of auto/fixed object collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Rt. 235 Fir. Jerome Neck Rd. Dameron, Md.			STATE				
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Margarita Korell</i>					TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 8-19-83				
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8-23-83		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial			23d. LOCATION CITY OR TOWN California, St. Mary's, Md.		COUNTY STATE			
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home, Leonardtown, Maryland								25a. DATE REC'D. BY REGISTRAR AUG 25 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>		
BP												
DHMH - 17 (VR A15 ME (5)) 20M 4/B2												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22590		
												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Muriel Angeline Mattingly						August 15, 1983			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 MRS. HOURS MIN.		
Female		White		Oct. 11, 1911			71			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.				
Pennsylvania		U.S.A.												
10. CITY OR TOWN OF DEATH Avenue		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			at home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
								Homemaker						
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Avenue			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Mattingly Road 20609				
14. FATHER'S NAME O. J.		MIDDLE McCollough		LAST			15. MOTHER'S MAIDEN NAME Jessie			LAST Dingman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No		189-10-0190			Helen Neilly			same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure of major organ systems												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.														
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pulmonary (lung) cancer														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/01/82</u> to <u>12/01/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (had) (did not) view the body after death.												22c. DATE SIGNED 8/17/83		
22b. SIGNATURE <i>DeLoach</i>												DEGREE		
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME Eugene Gazzola, M.D.		22e. ADDRESS Chaptico, Maryland 20621												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8/18/83		23c. NAME OF CEMETERY OR CREMATORIAL All Saints			23d. LOCATION CITY OR TOWN Oakley			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR AUG 18 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>						

RM

London, March 20, 1918
Robert Murphy, of the Foreign
Ministry, of the

10th Regt. (Infantry)

2/18

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

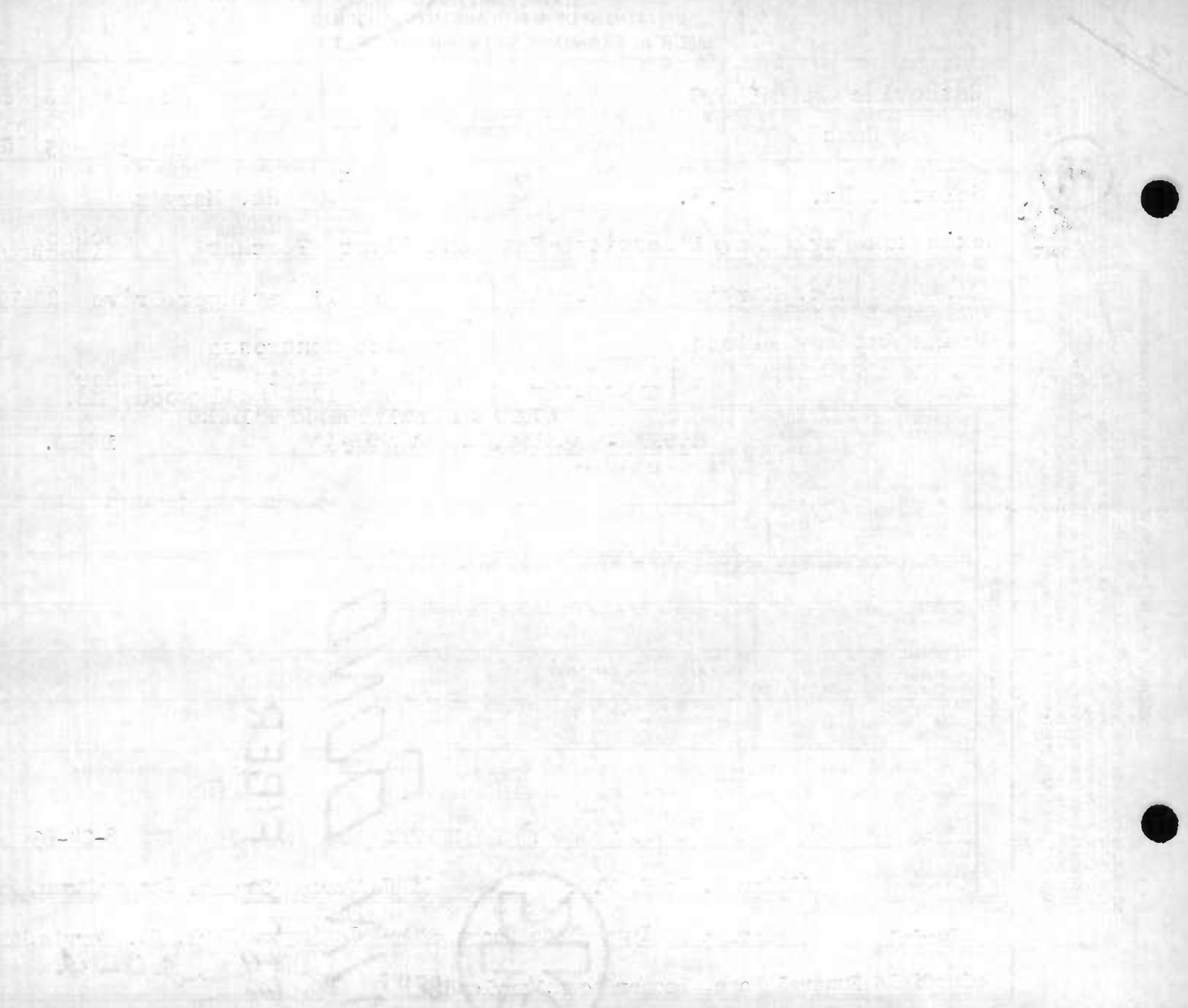
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22591

REG. NO.

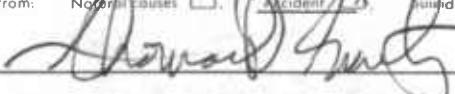
1- STATE REGISTRAR	2a. DATE KNOWN OF DEATH ESTIMATED						2b. HOUR 0116 a.m.		
Catherine NMN MILETO						Aug 24 1983	24 HOUR 0116 a.m.		
3. SEX F	4 RACE Cauc	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) 66 yrs.	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	Aug 24 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Galeton, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's			
10 CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital Patuxent River				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			
13a. STATE Md.		13b. COUNTY St. Mary's	13c. CITY OR TOWN California	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 111 Baringer Drive 20619			
14. FATHER'S NAME FIRST Frank Anthony Miletto		15. MOTHER'S MAIDEN NAME FIRST Domenica Montrossa							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-18-5606		17. INFORMANT Louis A. Miletto - Brother Rt 1 Box 1265 Hollywood, Md.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>Respiratory</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Alasdair Boyd, M.D.</u> TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd, M.D. ADDRESS 17 Jefferson Street, Leonardtown, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-83		23c. NAME OF CEMETERY OR CREMATORIAL Immaculate Heart of Mary Lexington Park, St. Mary's, Md.		23d. LOCATION CITY OR TOWN		COUNTY	STATE
24 FUNERAL DIRECTOR NAME <u>Brinsfield Funeral Home, Leonardtown, Maryland</u> ADDRESS <u>SEP 6 1983</u>								25. DATE REC'D. BY REGISTRAR (S.B. REGISTRAR'S SIGNATURE) <u>John G. Conner</u>	
BP		DHMH - 17 (VR A15 ME (5)) 20M 4/B2							

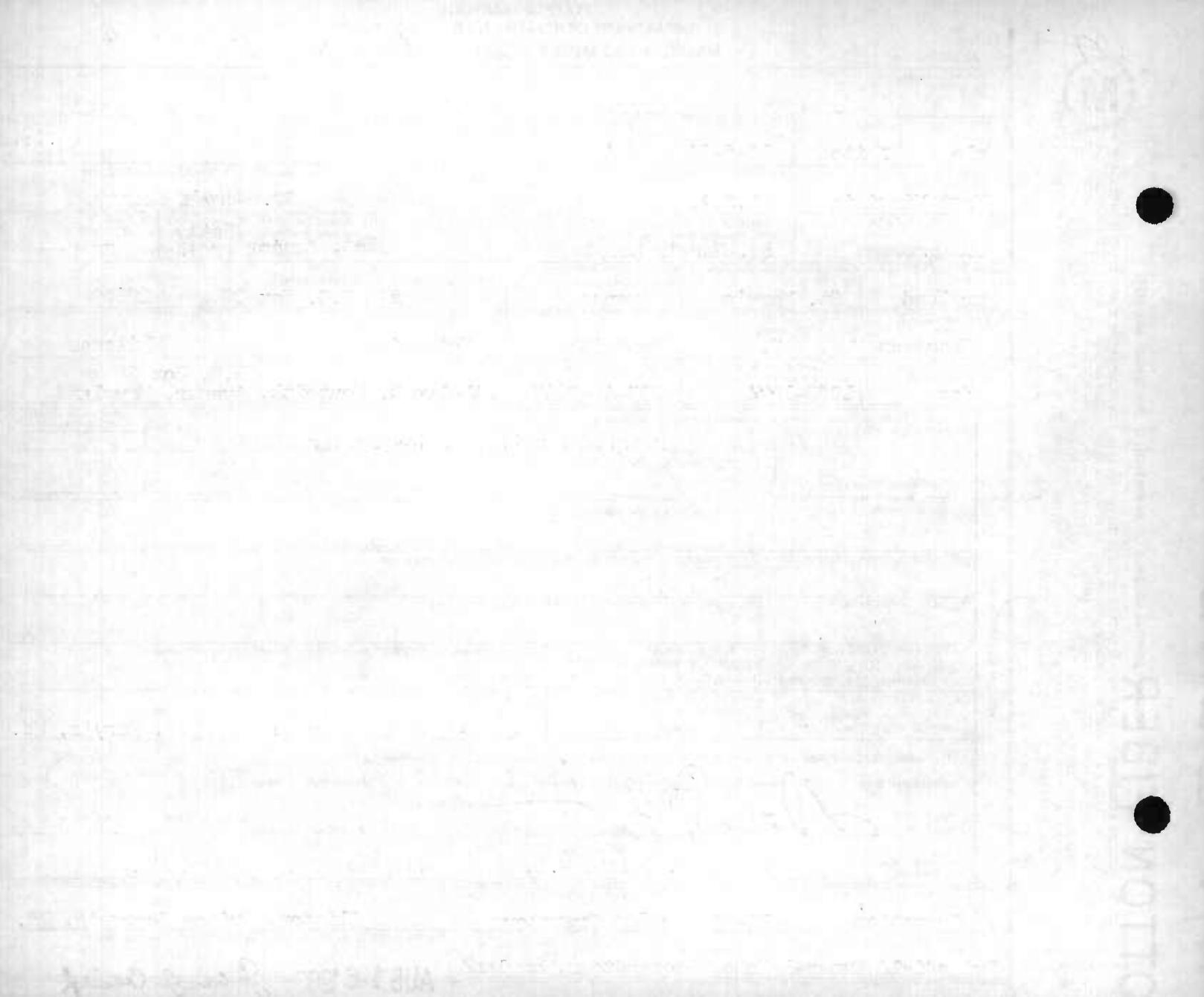


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR INFORMATION. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22592
REG. NO.

1- STATE REGISTRAR			2a DATE KNOWN OF EST-DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 8 19 83 M												
1. DECEASED NAME FIRST MIDDLE LAST Ronald Chasteen Monteith			2b HOUR 11:18 a.m.												
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-5-34		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 8 19 83					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD.									
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Petty Ret. Senior Officer			12b. KIND OF BUSINESS OR INDUSTRY US Navy						
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Avenue		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 38		20609					
14. FATHER'S NAME FIRST Chasteen MIDDLE T. LAST Monteith			15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE LAST Whiteman												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1952-1974			17. INFORMANT ADDRESS P.O. Box 38			Ethelyn W. Monteith, Avenue, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF 9053 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). Bee Sting															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:45 AMX 8 8 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stung by bee		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21e. LOCATION STREET P.O. Box 38		CITY OR TOWN Avenue		COUNTY St. Mary's, Md.		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER										DATE SIGNED 8/9/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-12-83		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Clinton		COUNTY Prince George's, Md.		STATE					
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home, Leonardtown, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 16 1983										25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22593			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
= JAMES MICHAEL O'BRIEN						08 19 83						1130A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUC		MONTH NOV DAY 18 YEAR 48			34			MONTHS 08	YEARS 1	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			ST MARY'S CALVERT COUNTY MD.			
CLEVELAND, OHIO US		US											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			20653			
LUSBY, MD.		NAVAL HOSPITAL, PAX RIVER, MD		PILOT									
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			PAX. RIVER, MD			
MD.		ST MARY'S		LEX. PARK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			928D SHEPARD TERRACE, NAS			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
JAMES		O'BRIEN		JEANNE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			928 D Shepard Terrace			
YES		70DEC/AUG83 274-48-8877		JANICE R. O'BRIEN, Patuxent River, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple traumatic injuries secondary to</u> DUE TO, OR AS A CONSEQUENCE OF 8411													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1127 P.M. 8 19 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Aircraft Accident		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AH-1S Helicopter			21f. LOCATION STREET Lusby		CITY OR TOWN COUNTY Lusby		CITY OR TOWN COUNTY Calvert MD				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 20 Aug 83			
22b. SIGNATURE <i>David R Andrews, M.D.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) David R. ANDREWS LCDR, MC, USNR			22e. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								
22f. ADDRESS Naval Hospital, NAS, Patuxent River, MD 20670													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-24-83			23c. NAME OF CEMETERY OR CREMATORIAL AURORA			23d. LOCATION CITY OR TOWN CHAGRIN FALLS, CUYAHOGA, OHIO		COUNTY STATE			
24. FUNERAL DIRECTOR NAME BRINSFIELD FUNERAL HOME, LEONARDTOWN, MARYLAND		ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 26 1983			REGISTRAR'S SIGNATURE <i>John J. Cawley</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

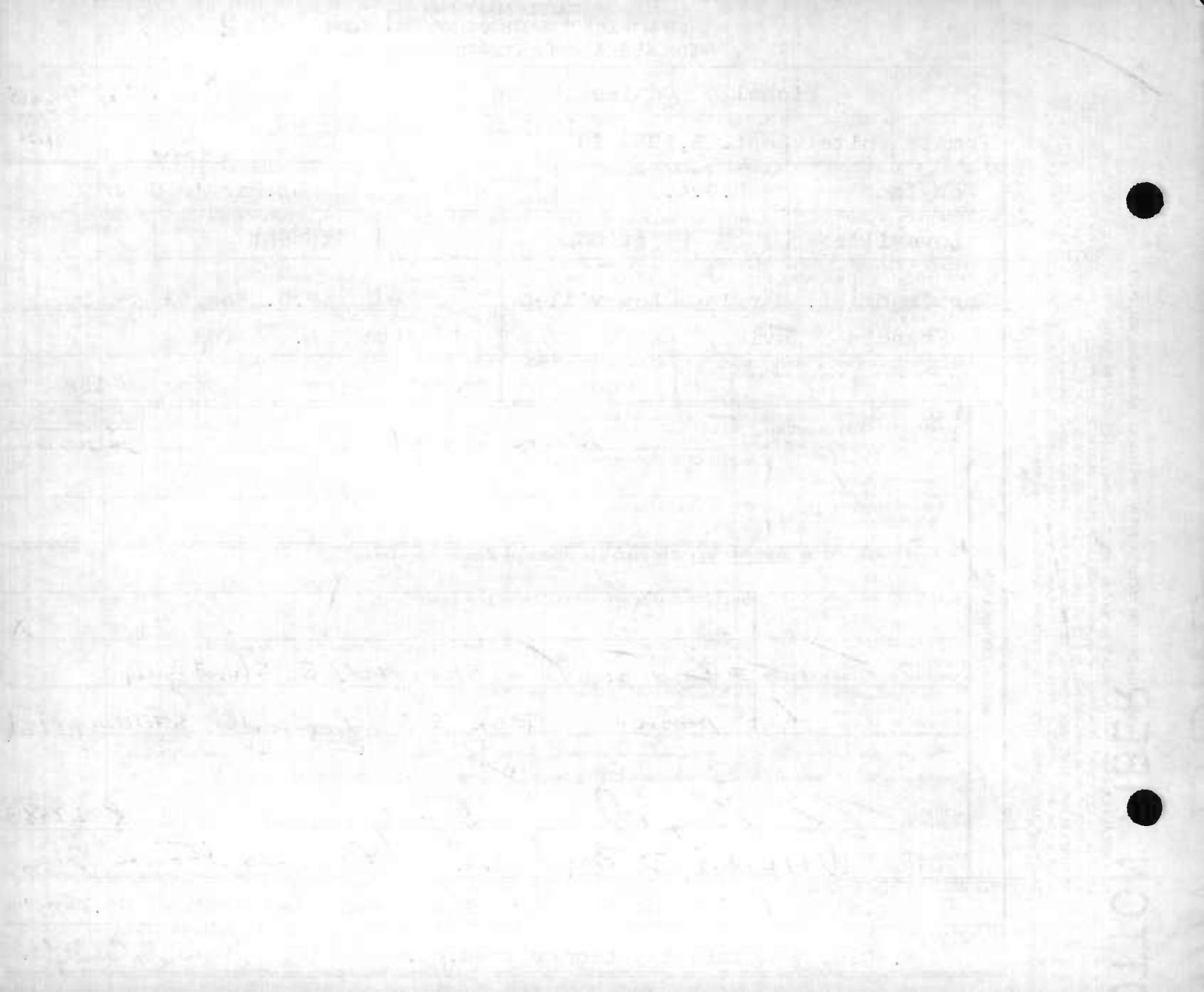
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22594

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR	
Michelle Denise Payne						<input checked="" type="checkbox"/> Aug. 21, 1983			19			6:31 P.M.	
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9c. DATE PRONOUNCED DEAD	10. DATE MONTH DAY YEAR	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	MD.		
Female	White	Sept. 23, 1968 14	YRS.	MONTHS DAYS	HOURS MIN	Same	19	at home	Student		M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			St. Mary's County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Loveville		at home									MD.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		St. Mary's		Loveville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 53		20656			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
Francis Xavier Payne				Loretta A. Cox		No			none			Francis Payne same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9551</u> <u>Gun Shot -</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>injured</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:15 AM 8 21 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>shot self & shot gun</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET <u>Box 53</u> CITY OR TOWN <u>Loveville</u> COUNTY <u>St. Mary's</u> STATE <u>MD</u>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion							
ACTUAL SIGNATURE <u>William P. Boyd</u>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)									DATE SIGNED <u>8-22-83</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/23/83			23c. NAME OF CEMETERY OR CREMATORIAL Charles Memorial Gardens			23d. LOCATION CITY OR TOWN <u>Leonardtown</u> COUNTY <u>St. Mary's</u> STATE <u>MD</u>				
24. FUNERAL DIRECTOR NAME			ADDRESS W. Clarke Mattingley Leonardtown, Md			25a. DATE REC'D. BY REGISTRAR AUG 26 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22595

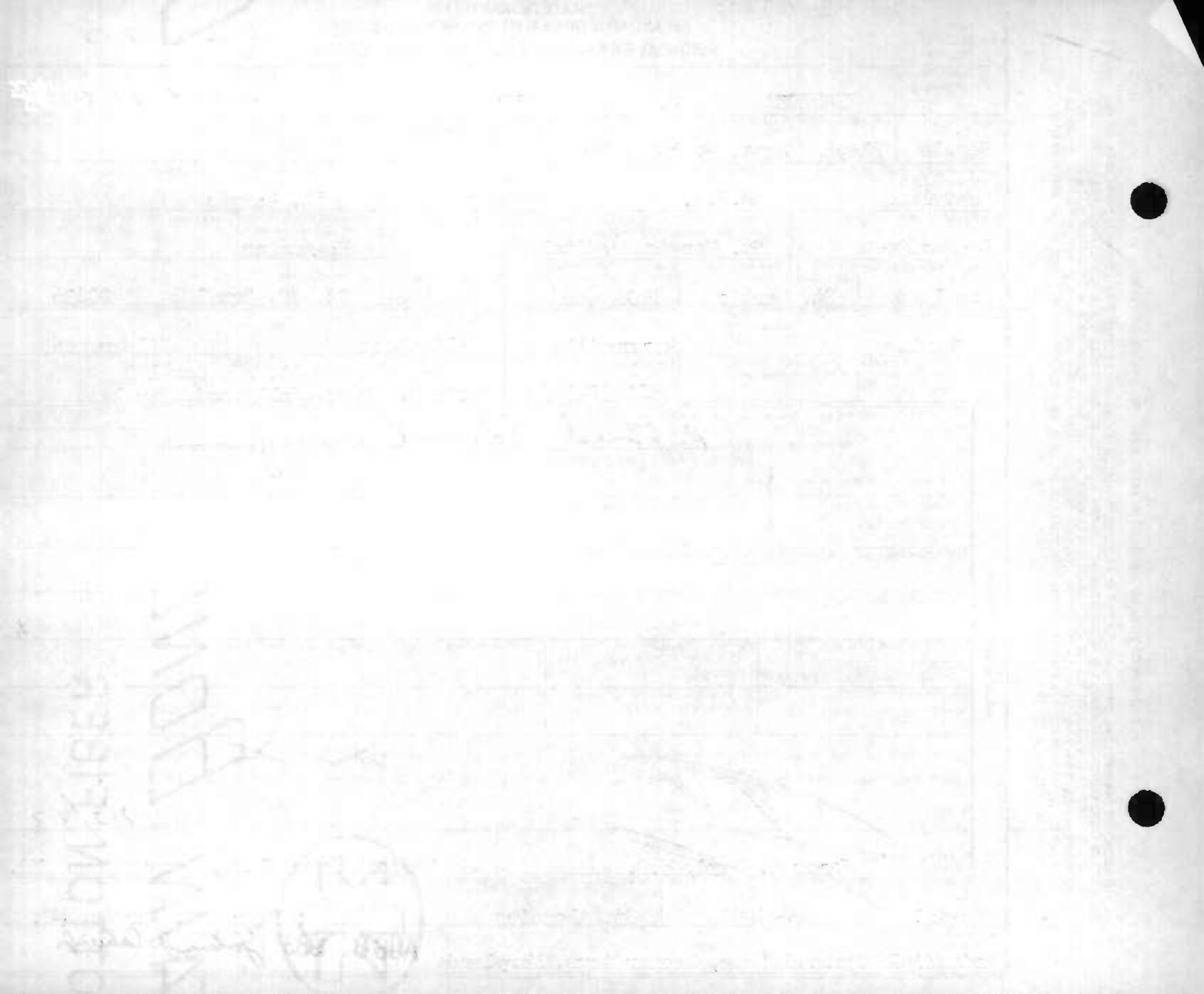
REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b HOUR 2:31 A.M.
BERNICE C. PRICE						✓ 8	1	1983		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 19 M
Female	Black	Sept. 9, 1912	70 yrs.	MONTHS	MONTHS	19				
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	St. Mary's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtown		St. Mary's Hospital			Homemaker					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Maryland		St. Mary's	Hollywood	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #2, Box 192		20636		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Charles			Sommerville	Elizabeth			Lawrence			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
No		218-30-3059			Sarah C. Price, Hollywood, Maryland		Rt. #2, Box 192			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ruptured abdominal aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
23. ACTUAL SIGNATURE TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED 8/3/83										
23a. EXAMINER'S NAME (TYPE OR PRINT)		James C. Boyd, M.D.			ADDRESS			Medical Arts Bldg., Leonardtown, Md.		
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. DATE		23d. NAME OF CEMETERY OR CREMATORIAL LOCATION CITY OR TOWN			23e. COUNTY STATE			
Burial		8-4-83		St. Aloysius			Leonardtown, St. Mary's, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Brinsfield Funeral Home, Leonardtown, Maryland					AUG 6 1983		John J. Coughlin			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PM-3. RETAIN PAGES 5, FORM PM-3, AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22596				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Joseph Irving Price									2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED X 8 15 1983 1400M				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Aug. 19, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 8 15 1983 2130		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.								
10. CITY OR TOWN OF DEATH St. James			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY 20653							
13a. STATE Maryland			13b. COUNTY St. Mary's			13c. CITY OR TOWN Lexington Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 187						
14. FATHER'S NAME FIRST Charles			MIDDLE Price			15. MOTHER'S MAIDEN NAME FIRST Madeline		MIDDLE Raley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-03-0863			17. INFORMANT James Price			ADDRESS Rt. 5 Box 60 Scotland, Md. 20687							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5799 GASTROINTESTINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE		23. TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			DATE SIGNED 8-17-83											
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, M.D.			ADDRESS LEONARDTOWN, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/18/83			23c. NAME OF CEMETERY OR CREMATORIAL Holy Face			23d. LOCATION CITY OR TOWN Great Mills							
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley			ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR AUG 18 1983			25b. REGISTRAR'S SIGNATURE John G. Conroy							
20M 4/82																
DHMH - 17 (VR A15 ME (5))																

O. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 _____
filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the _____ hours after death. _____
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NO HOSPITAL OR ATTENDING PHYSICIAN. The

BP _____
DMMH - 16 50M 4/B
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22597

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WARREN			MIDDLE WALTER			LAST PROCTOR			20. DATE OF DEATH MONTH DAY YEAR August 11, 1983			2b HOUR 12:15am		
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1898			6. AGE (IN YEARS LAST BIRTHDAY) 85 yrs.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's			MD				
10. CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming							
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bel Alton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS General Delivery 20611				
14. FATHER'S NAME FIRST Bennie		MIDDLE 		LAST Proctor			15. MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE Proctor		LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-38-1431		16c. INFORMANT Blanche E. Proctor			16d. ADDRESS Same as No. 13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) Pneumonia														
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure														
DUE TO, OR AS A CONSEQUENCE OF (c) 														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/83 , 19 83 , to 8/11 , 19 83 , that (I) (we) last saw the deceased alive on 8/4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED			8/11/83			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D.		22g. ADDRESS Medical Arts Bldg., Leonardtown, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 15, '83		23c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius			23d. LOCATION CITY OR TOWN Chapel Pt. Charles			COUNTY Md.		STATE		
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.		ADDRESS 17000 0			25a. DATE REC'D. BY REGISTRAR 17000 0			25b. REGISTRAR'S SIGNATURE						

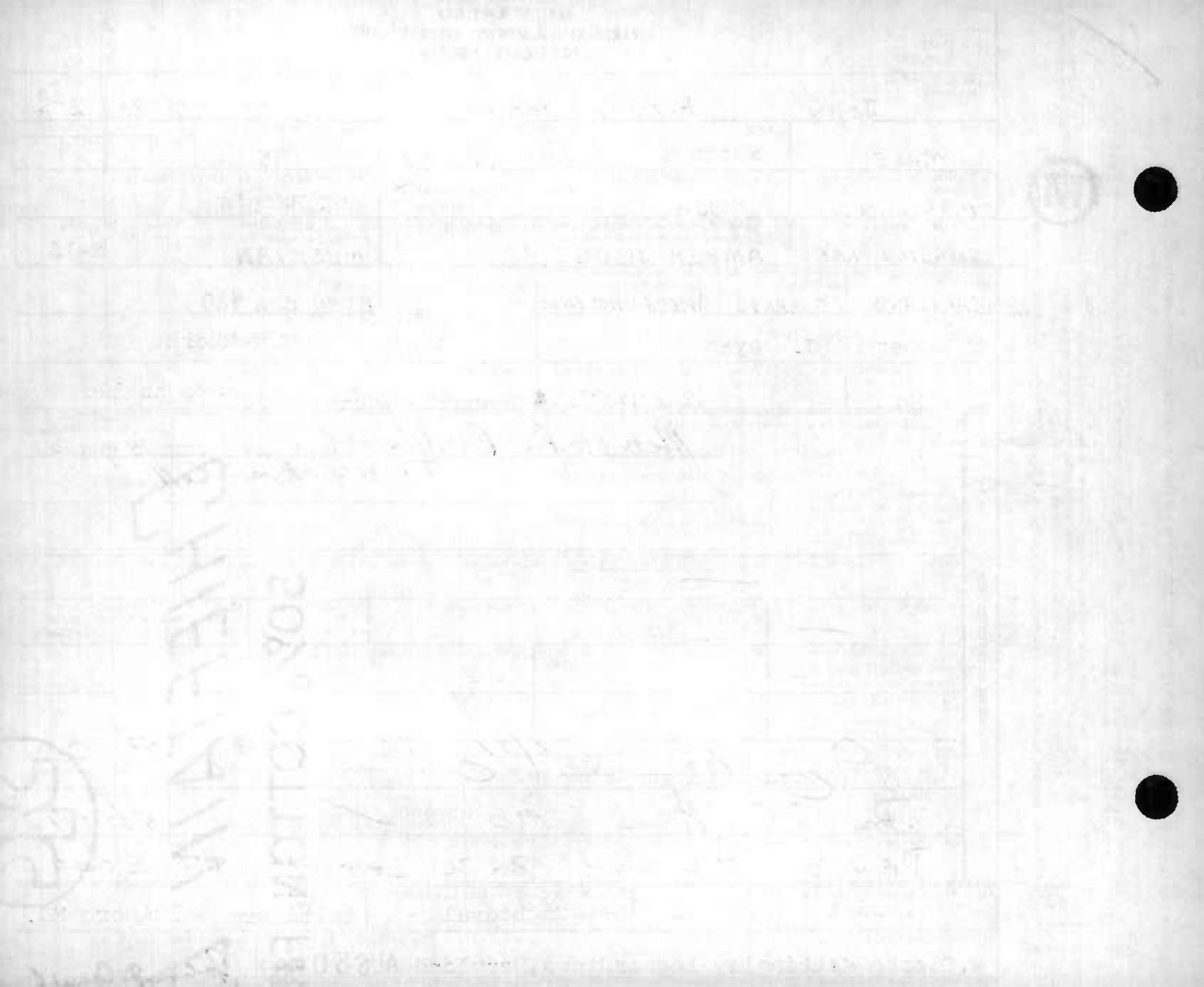
837 A. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22598				
										REG. NO.				
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
	JOHN			Anthony RYAN			08 27 83					83	220 AM	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE	White		MONTH	DAY	YEAR	75 yrs.			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MARYLAND	USA						St Mary's							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
LEXINGTON PARK	AMBER HOUSE			MUSICIAN			Self							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
MARYLAND	ST. MARYS	MECHANICSVILLE			YES <input type="checkbox"/> NO <input type="checkbox"/>			RT#4 Box 437			20659			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Robert	J.	Ryan		Annie			Gavenkort							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No	216-12-9826			Jeanette Young			same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1889</i> <i>Metastatic Bladder C2</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Trans, renal Cell</i>										3 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> 19 <i>83</i> to <i>8/26</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>8/26</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>David C. Allen</i>				DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/27/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID ALLEN</i>	22e. ADDRESS Box 301 Leonardtown Md 20650													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/31/83	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral			23d. LOCATION CITY OR TOWN Baltimore			COUNTY	Baltimore		MD.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley	ADDRESS Leonardtown, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 30 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Clegg</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22599			
REG. NO.													
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
	JOSEPH					SINARDI	8 - 30 - 83						8:45 PM
3. SEX	4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White			11	5	08	74			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Florida	U.S.A.						St. Mary's			MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Lexington Park	Amber House Nursing Home			Presser			Clothing						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland	Montgomery	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			511A South Frederick Ave. 20760							
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
	UNKNOWN		UNKNOWN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No	130-10-1524			Walter R. Bishop, Rockville, Maryland 20851									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) 2900													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory, septic</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-16-82, 19, to 19, that (I) (we) last saw the deceased alive on 8-21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE DEGREE													
22c. ATTENDING PHYSICIAN						MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED			
James C. Boyd, M.D.										8/24/83			
22e. ADDRESS													
James C. Boyd, M.D.						Medical Arts Bldg, Leonardtown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation	9-1-83			Lee's Crematory			Clinton			Prince George's, Md.			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR			
Brinsfield Funeral Home, Leonardtown, Maryland										25b. REGISTRAR'S SIGNATURE			
SEP 9 1983										John & Carl			

LOSE CO. 10



1000

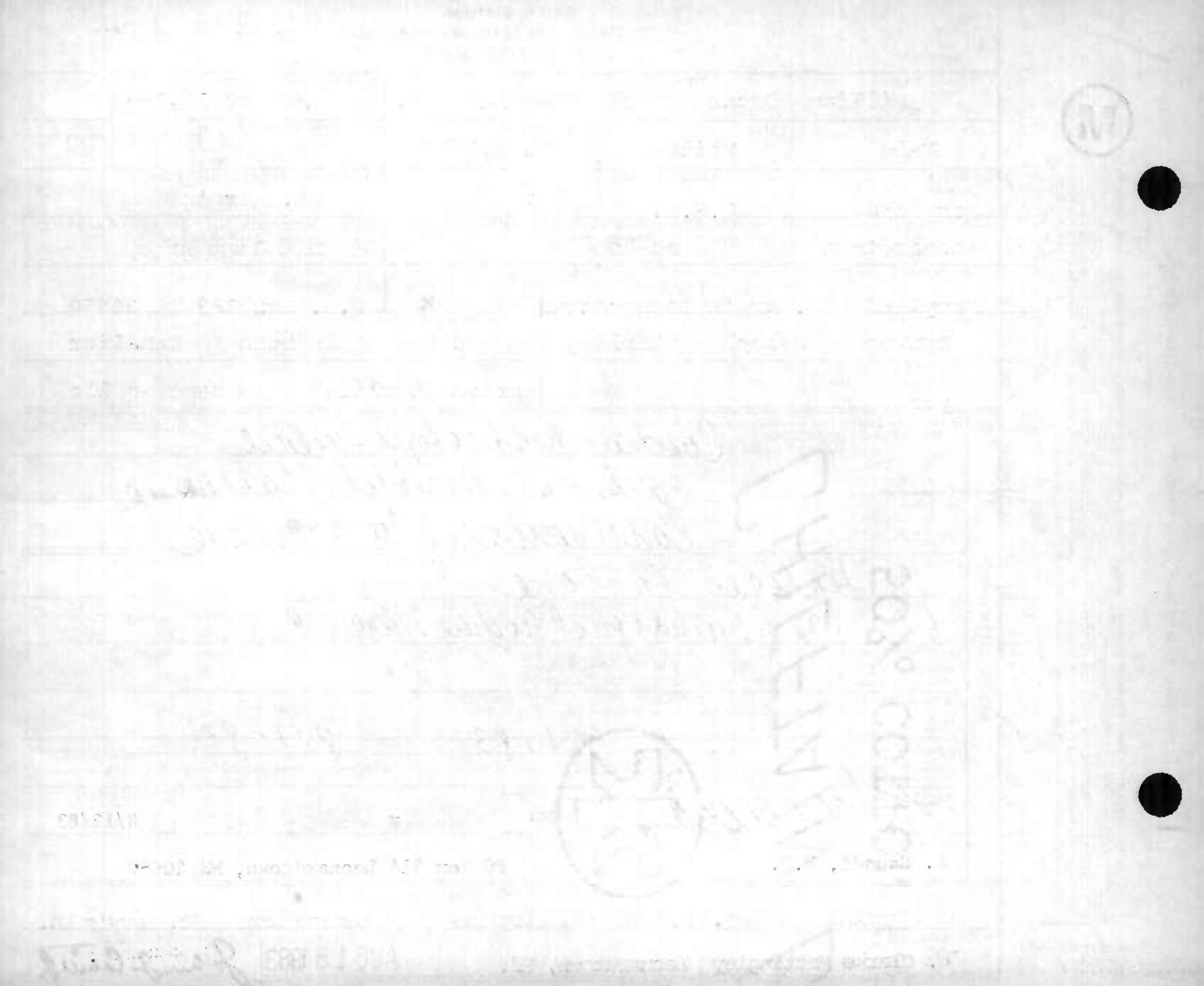
1000 10,932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22600				
1 - FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
William Oscar Enoch Sterling Sr.						August 11, 1983								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		March 2, 1916			67			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.A.					St. Mary's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown		at home					District Court Judge							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland		St. Mary's		Leonardtown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			P.O. Box 282 20650				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME										
		Lynwood Joseph Sterling		Ruth Elizabeth Camalier										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
yes				Marion Sterling			same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for item 18, Part 1 and 2) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) Cachexia - Melanotic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the prostate														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
6/2/83		Pathological specimen of prostate		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		8/11/83		19			to 8/11/83			19				
22b. SIGNATURE		22c. DEGREE		MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
A. Samadi, M.D.													8/12/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE				
Burial		Aug. 13, 1983		St. Aloysius			Leonardtown			St. Mary's Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
W. Clarke Mattingley		Leonardtown, Md.					AUG 18 1983			John G. Cawie				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22601			
1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input checked="" type="checkbox"/> OF EST- DEATH MATED		MONTH 8	DAY 25	YEAR 1983	2b. HOUR 2100		
		MARY EVANGELINE SWANN						<input type="checkbox"/>							
3. SEX 4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. DATE PRONOUNCED DEAD MONTH 8		DAY 25	YEAR 1983	2d. HOUR 2100	
Female Black		Mar. 1, 1917		66 yrs.						<input checked="" type="checkbox"/>		St. Mary's County			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED		WIDOWED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		U.S.A.						<input type="checkbox"/>		<input type="checkbox"/>		St. Mary's County			
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtown		St. Mary's Hospital						Housewife		99999					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
				Washington, D.C.				309 V Street, N.W. 20001							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Phil		SARAH STEWART													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> No		16b. SOCIAL SECURITY NO. 579-20-9810		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				John A. Swann, Washington, D.C. 20001		IMMED.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF 4100 Conditions, if any, which gave rise to immediate cause (o) stating the <u>under-</u> lying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Wm D. Boyd</i>		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER						DATE SIGNED 8-26-83							
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, MD		ADDRESS JEFFERSON STREET, LEONARDTOWN, MD.													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 8/30/83		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY		23d. LOCATION CITY OR TOWN LANDOVER		23e. COUNTY MD							
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		ADDRESS 4339 HUNT PLACE, N.E.		25a. DATE REC'D. BY REGISTRAR SEP. 1 - 1983		25b. REGISTRAR'S SIGNATURE <i>John G. Cawley</i>									
20M 4/82															

OFFICES FUNERAL HOME, INC.
4333 HUNT PLACE, N.E.
WASHINGTON, D.C. 20016

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 2. RETAIN PAGE 5 FOR FURTHER USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										22602						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR M			
STANLEY SCOTT DAVID VASKUS								<input checked="" type="checkbox"/>		8	21	1983	1615			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR M			
Male	White	11 13 54	28 yrs.							8 22 1983			0900			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		U.S.A.		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		St. Mary's MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
St. Inigoes		Smith Creek		Salesman		Music					99999					
13a. STATE Pennsylvania										13b. COUNTY Philadelphia		13c. CITY OR TOWN Philadelphia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 318 West Sparks Street 19120	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		Vickonis				
Albert				Vaskus		Anna										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
No				James Vaskus,		8842 Tamar Dr., Apt. 301 Columbia, Maryland 21045										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1 DEATH WAS CAUSED BY: 9102 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										8 hours						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?												
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input type="checkbox"/> MONTH DAY YEAR 4:15 P.M. 8-21-1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Step off into deep water while Wading												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ARMED, ETC.) Smith Creek		21f. LOCATION STREET CITY OR TOWN ST. Inigoes COUNTY ST. MARY'S MD STATE												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dr. William D. Boyd</i> M.D. Deputy MEDICAL EXAMINER										TITLE (SPECIFY)						
EXAMINER'S NAME (TYPE OR PRINT)										DATE SIGNED 8-22-83						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-23-83		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Clinton, Prince George's, Md.										
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home, Leonardtown, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 26 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conigli</i>										
BHHS - 17 (VR A15 ME (5))																
20M 4/82																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial certificate. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8/3 22603				
1 - STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
HOWARD			GEORGE WATKINS			August 19, 1983			11:40 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male		White		Dec. 9, 1912			70			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
North Carolina		U.S.A.					St. Mary's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown		St. Mary's Hospital		Carpenter			Civil Service							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland		St. Mary's		California		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Star Route, Box 239		20619				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Frank		Cora			Howard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		235-18-9969		Mrs. Inez C. Watkins		Star Route, Box 239								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										ADDRESS (IMMEDIATE PRECEDING BETWEEN ONSET AND DEATH)				
IMMEDIATE CAUSE (a) <i>4100 Acute Myocardial Infarction</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>with cardiogenic shock</i>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 78, to 19 83, that (I) (we) last saw the deceased alive on 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.										22c. DATE SIGNED				
22b. SIGNATURE <i>James C. Boyd, M.D.</i>										DEGREE				
22d. PHYSICIAN'S NAME (IF OTHER THAN DECEASED)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS <i>Leonardtown, Md.</i>										22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY					
Burial		8-22-83		Evergreen Memorial			California		St. Mary's, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Brinsfield Funeral Home, Leonardtown, Maryland				AUG 25 1983			John J. Schmid							

Q100

Q101, 81 degrees

Q1002

Q1003

Q1004

Q1005, 81 degrees

Indicated a gear with modifications

Q1006, 81 degrees

Indicated a gear with modifications

20% Cotton

81, modifications

Q101, 81, 81, 81

X5

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22604

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			GEORGE	HENRY	WELTY	August 15, 1983				10:13M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Sept. 30, 1889		93		YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County							
Wash. D.C.		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtown		St. Mary's Hospital				Rural Route Box 1A7						20618	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		St. Mary's		Bushwood									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Hiram Eagle		Gertrude Elizabeth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		578-14-9380A		Lorraine Lacey		Rt. 238 Box 1A7 Bushwood, Md.							
18. CAUSE OF DEATH (Enter only one cause per line. See Part 1, Item 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>inflammation</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/15/83</i> , 19____, to <i>8/15/83</i> , 19____, that (I) (we) last saw the deceased alive on <i>8/15/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John D. Boyd</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/16/83</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
William D. Boyd, M.D. II		Leonardtown, Md. 20650											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		8/19/83		Sacred Heart		Bushwood St.		St. Mary's Md.					
24. FUNERAL DIRECTOR NAME <i>W. Clarke Mattingley</i>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John D. Boyd</i>									
		AUG 18 1983											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial Transit Permit. Then, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5000

£800,000,000

1960

1961

1962



1960 £1,000,000

£1,000,000

1961 £1,000,000

1962 £1,000,000

1963 £1,000,000

1964 £1,000,000

1965 £1,000,000

1966 £1,000,000

Office of Information 11.00 AM 19th. 11. 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22605							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
ROBERT			EDWARD	WENTWORTH				August 10, 1983						6:35 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male		White		Oct. 14, 1927						55			YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Washington, D.C.		U.S.A.									St. Mary's County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Leonardtown		St. Mary's Hospital								Nurseryman			Ret. Sales				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland		St. Mary's		Leonardtown			YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	P.O. Box 209			20650					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
		Howard	C.	Wentworth	Heleda						Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS										
No		220-12-3822		Priscilla D. Wentworth, Leonardtown, Maryland			P.O. Box 209										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Congestive Heart Failure</i>																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
										YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f.													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 77, to 8/10, 19 83, that (I) (we) last saw the deceased alive on 8/10, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8/11/83							
22a. SIGNATURE <i>James C. Boyd, M.D.</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D.										22c. ADDRESS Leonardtown, Md. 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8-13-83		23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius Catholic Leonardtown, St. Mary's, Md.			23d. LOCATION CITY OR TOWN		COUNTY		STATE						
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home, Leonardtown, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 16 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Cawley</i>										
BP																	
DHMH - 16 50M 4/82 (VRA 15, 4)																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22606			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR	
MAXINE C. WILCE									AUGUST 10, 1983			M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			Aug. 28, 1923			59 YRS.			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Plymouth, Penna			USA						St Mary's				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtown			at home						Home maker			20650	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										224 Jefferson St. Box 412			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		St. Mary's		Leonardtown					224 Jefferson St. Box 412				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
John GREEN			Rose KUSMA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			193-16-8124			Gerald Wilce same as # 13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4/100</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Occlusion</i>													
DOUE TO, OR AS A CONSEQUENCE OF (c) <i>hr.</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.										22c. DATE SIGNED <i>8/11/83</i>			
22b. SIGNATURE <i>J. Patrick Jarboe M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Patrick Jarboe M.D.</i>			22e. ADDRESS <i>Leonardtown, Maryland</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Aug. 13, 1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Nativity Plymouth</i>			23d. LOCATION CITY OR TOWN <i>Plymouth</i> COUNTY STATE <i>Penna</i>				
24. FUNERAL DIRECTOR NAME <i>W. Clarke Mattingley</i>			ADDRESS <i>Leonardtown, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 15 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John G. Conner</i>				

